MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address RS Medical P.O. Box 872650 Vancouver, WA 98687-2650	MDR Tracking No.: M5-04-0225-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Employers Insurance Co. of Wausau c/o Liberty Mutual Box 28	Date of Injury: Employer's Name: Insurance Carrier's No.: 197527381

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/10/03	06/09/03	E1399	500.00	500.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary states in part, "…(ii) Payment has been made based on old fee guidelines for E0745; which had a D code in the pre 1996 fee schedule, which is not a comparable device as it provides only muscle stimulation. The Commission has not established a maximum allowable for the RS4I Sequential Stimulator. The RS4I provides 2 modalities… 4 channel muscle stimulation plus interferential electrotherapy, providing equivalent therapy of 2 devices, therefore a higher fee allowance is reasonable and warranted… (iv) We have provided product information and pricing documentation along with the prescription from the patient's doctor of records. We are also including copies of EOBs from carriers who are paying at our list price…"

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary states in part, "…Charges in dispute are stimulator rental for dates of service, 1/10/03 through 6/9/03, which were paid at a rate of $150.00 per month. According to the Medical Fee Guidelines page 254 section IX paragraph C, 'Reimbursement shall be an amount pre-negotiated between the provider and carrier or reimbursement shall be the same as the fees set for the "D" codes in the 1991 Medical fee Guideline'."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

It is unclear as to the reason the dispute was docketed as a medical necessity dispute. Liberty Mutual sent a fax on 9/30/03 stating there were no medical necessity issues. Therefore, this dispute will be reviewed according to the 1996 MFG and TWCC Act and Rules.

- HCPCS Code E1399 for dates of service 01/10/03 through 06/09/03 (5 dates of service) denied as "F". The requestor billed $250.00 for each date of service for the RS4I stimulator; the carrier reimbursed the requestor $150.00 per date of service citing the 1996 MFG/DME Ground Rule (IX)(C) which allow $150 per month for a muscle stimulator. Per Rule 133.1(a)(8) the requestor has provided product and pricing information supporting that the RS4I is not only a muscle stimulator but also interferential electrotherapy device. The requestor also provided copies of redacted EOBs from other carriers which support the amount billed as their fair and reasonable amount billed. Additional reimbursement in the amount of $500.00 is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
1/10/2003 -							
2/9/2003	E1399	$100.00	$100.00				
02/10/03 -							
3/9/2003	E1399	$100.00	$100.00				
03/10/03 -							
4/9/2003	E1399	$100.00	$100.00				
4/10/2003 -							
5/9/2003	E1399	$100.00	$100.00				
05/10/03 -							
6/9/2003	E1399	$100.00	$100.00				
						Total Left Column:	$500.00
						Total Amount Due:	$500.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $500.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster	01-07-05
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____